(Contract Period _____ to _____ )

Contract With Eligible Medicare+Choice Organization Pursuant to sections 1851 through 1859 of the Social Security Act for the operation of a Medicare+Choice coordinated care plan(s)

CONTRACT (P_____ )

Between

Health Care Financing Administration (hereinafter referred to as HCFA)

and

_____

(hereinafter referred to as the M+C Organization)

HCFA and the M+C Organization, an entity which has been determined to be an eligible Medicare+Choice organization by the Administrator of the Health Care Financing Administration under 42 CFR 422.501, agree to the following for the purposes of sections 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the authority for certain contract provisions in the regulations promulgated pursuant to the Balanced Budget Act of 1997. All references to part 422 are to 42 CFR part 422.)

## Article I

## Term of Contract

A. Term: The term of this contract shall be from January 1, 1999 through December 31, 1999. This contract governs the transitional phase of the implementation of the Medicare+Choice program for coordinated care plans and is based on the interim final regulations published on June 26, 1998.

**[422.504]**

## Article II

## Coordinated Care Plan

The Medicare+Choice Organization agrees to operate the following coordinated care plans (as defined in 42 CFR § 422.2) in compliance with the requirements of this contract, and the Federal statutes, regulations, and rules applicable to the Medicare+Choice program:

| | |
|---|---|
| _____ | _____ |
| "H" Number/Service Area | "H" Number/Service Area |
| _____ | _____ |
| "H" Number/Service Area | "H" Number/Service Area |

## Article III

## Functions To Be Performed By Medicare+Choice Organization

A. PROVISION OF BENEFITS

The M+C Organization agrees to provide enrollees in each of its M+C plans the basic benefits as required under § 422.101 and, to the extent applicable, supplemental benefits under § 422.102. The M+C Organization agrees to provide access to such benefits as required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in § 422.112.

**[422.502(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The M+C Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of part 422.

2. The M+C Organization shall comply with the provisions of § 422.110 and § 422.111 concerning prohibitions against discrimination in beneficiary enrollment.

**[422.502(a)(1)]**

C. BENEFICIARY PROTECTIONS

1. The Medicare+Choice Organization agrees to comply with all requirements in subpart M of part 422 governing coverage determinations, grievances, and appeals. **[422.502(a)(7)]**

2. The Medicare+Choice Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in § 422.118.

3. Beneficiary Financial Protection. The M+C Organization agrees to comply with the following requirements:

(a) Each M+C Organization must adopt and maintain arrangements satisfactory to HCFA to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the M+C organization. To meet this requirement the M+C Organization must--

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the M+C Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the M+C Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the M+C Organization, to provide services to the organization's beneficiary enrollees. **[422.502(g)(1)]**

(b) The M+C Organization must provide for continuation of enrollee health care benefits--

(i) For all enrollees, for the duration of the contract period for which HCFA payments have been made; and

(ii) For enrollees who are in an inpatient setting on the date its contract with HCFA terminates, or, in the event of an insolvency, through the date of discharge. **[422.502(g)(2)]**

(c) In meeting the requirements of this section (C), other than the provider contract requirements specified in paragraph (C)(3)(a) of this Article, the M+C Organization may use--

(i) Contractual arrangements;

(ii) Insurance acceptable to HCFA;

(iii) Financial reserves acceptable to HCFA; or

(iv) Any other arrangement acceptable to HCFA. **[422.502(g)(3)]**

D. PROVIDER PROTECTIONS

1. The M+C Organization agrees to comply with all applicable provider requirements in subpart E of part 422, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.506(a)(6)]**

2. Prompt Payment.

(a) The M+C Organization must pay 95 percent of the "clean claims" within 30 days of receipt if they are claims for services that are not furnished under a written agreement between the organization and the provider.

(i) The M+C Organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Act.

(ii) All other claims must be approved or denied within 60 calendar days from the date of the request. **[422.520(a)]**

(b) Contracts or other written agreements between the M+C Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the M+C Organization and the relevant provider. **[422.520(b)]**

(c) If HCFA determines, after giving notice and opportunity for hearing, that the M+C Organization has failed to make payments in accordance with paragraph (2)(a) of this section, HCFA may provide--

(i) For direct payment of the sums owed to providers, or M+C private fee-for-service plan enrollees; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the M+C Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM

1. The M+C Organization agrees to operate an ongoing quality assessment and performance improvement program (as stated in 422.154 of subpart D). The quality assurance program must incorporate and meet the standards and guidelines outlined in the Quality Improvement System for Managed Care (QISMC) Interim Standards and Guidelines (HCFA Operational Policy Letter 098.72).

2. Quality Assessment and Performance Improvement Projects: The M+C Organization agrees to:

(a) initiate two quality assessment and performance improvement (QAPI) projects annually. These projects must be outcomes-oriented and targeted at achieving demonstrable, sustained improvement in significant aspects of specified clinical and non-clinical areas which can be expected to have a favorable effect on enrollees' health outcomes and satisfaction. For 1999, one of the two projects must focus on diabetes. The M+C Organization may participate in the HCFA-sponsored national diabetes project or substitute a diabetes project of their own design; however, the substituted project must utilize the Diabetes Quality Improvement Project (DQIP) indicators.

(b) QAPI project focus areas must be representative of the entire spectrum of clinical and non-clinical care areas associated with a plan.

(i) The clinical areas include:

(aa) prevention and care of acute and chronic conditions

(bb)high-volume services

(cc)high-risk services

(dd)continuity and coordination of care

(ii) The non-clinical areas include:

(aa) appeals, grievances and other complaints

(bb) access to, and availability of services (such as culturally competent care).

(c) HCFA may require that the M+C Organization conduct a QAPI project in a particular clinical or non-clinical area when HCFA determines that the M+C Organization's overall performance would be improved significantly by the M+C Organization's improvement in that particular area. Such a HCFA-mandated QAPI project would constitute one of the two required QAPI projects.

(d) For each QAPI project, the M+C Organization must:

(i) use quality indicators that are objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research;

(ii) assure that those quality indicators are capable of measuring outcomes such as changes in health and functional status, enrollee satisfaction, or valid proxies of those outcomes;

(iii) assess performance on selected indicators using systematic on-going collection and analysis of valid, reliable data;

(iv) perform ongoing measurement of performance;

(aa) The M+C Organization must measure and report to HCFA performance achieved under the project, utilizing standard measures. The standard measures required by HCFA during the term of this contract will be uniform data collection and reporting instruments, to include the Health Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health of Seniors (HOS).

(bb) These measures must address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics.

**[422.152(c)(1)].**

(v) conduct system interventions, including the adoption and/or revision of practice guidelines;

(vi) improve performance; and

(vii) perform systematic follow-up on the effect of the interventions **[422.152(d)]**

3. Utilization Review: If the M+C Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services.**[422.152(b)(3)].** The M+C Organization must also have in effect mechanisms to detect both underutilization and overutilization of services.**[422.152(b)(4)]** .

4. Information Systems:

(a) The M+C Organization must make available to HCFA information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them, as provided in § 422.64(c)(10). **[422.152(b)(5)].**

(b) The M+C Organization must maintain a health information system that:

(i) collects, analyzes and integrates the data necessary to implement its quality assessment and performance improvement program, and

(ii) assures that the information entered into the system (particularly that received from providers) is reliable and complete.

(c) The M+C Organization must make all collected data, including information on quality and outcomes measures, available to HCFA to enable beneficiaries to compare health coverage options and select among them, as provided in § 422.64(c)(10). **[422.152(b)(5)]**

5. External Review: The M+C Organization will have an agreement with an independent quality review and improvement organization (review organization) approved by HCFA. **[422.154(a)]**

(a) The agreement will be consistent with HCFA guidelines and will:

(i) Require that the M+C Organization allocate adequate space for use of the review organization whenever it is conducting review activities and provide all pertinent data, including patient care data, at the time the review organization needs the data to carry out the reviews and make its determinations, and

(ii) Except in the case of complaints about quality, exclude review activities that HCFA determines would duplicate review activities conducted as part of an accreditation process or as part of HCFA monitoring. **[422.154(b)]**

F. COMPLIANCE PLAN

1. The M+C Organization agrees to develop and submit a compliance plan that includes the elements set forth below, and fully implement all elements of this plan by December 31, 1999. HCFA will consider the M+C Organization's progress in implementing this requirement as a factor in its decision, required by May 1, 1999, to renew the M+C Organization's contract for 2000. The compliance plan required under this article shall consist of the following:

(a) Written policies, procedures, and standards of conduct that articulate the M+C Organization's commitment to comply with all applicable Federal and State standards.

(b) The designation of a compliance officer and compliance committee that are accountable to senior management.

(c) Effective training and education between the compliance officer and organization employees.

(d) Effective lines of communication between the compliance officer and the organization's employees.

(e) Enforcement of standards through well-publicized disciplinary guidelines.

(f) Provision for internal monitoring and auditing.

2. The M+C Organization's compliance plan shall operate in such a manner as to ensure a prompt organizational response to detected offenses and development of corrective action initiatives. The compliance plan shall also establish an adhered-to process for reporting to HCFA and/or the Office of the Inspector General credible information of violations of law by the M+C Organization, plan, subcontractors or enrollees for a determination as to whether criminal, civil, or administrative action may be appropriate. With respect to enrollees, this reporting requirement shall be restricted to credible information on violations of law with respect to enrollment in the plan, or the provision of, or payment for, health services. When the potential violation of law concerns potential false claims or fraud on the United States, the M+C Organization shall report the information directly to HCFA and/or the OIG and shall not file actions under the qui tam provisions of the False Claims Act, 31 U.S.C. 3729, et seq.

**[422.501(b)(3)(vi)]**

G. YEAR 2000 READINESS

The M+C Organization shall ensure that all necessary actions and system changes to internal mission-critical systems have been made and tested so that they are Year 2000 compliant. Year 2000 compliant means information technology that accurately processes date and time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the nineteenth, twentieth, and twenty-first centuries, and the years 1999 and 2000 and leap year calculations. Furthermore, Year 2000 compliant information technology, when used in combination with other information technology,

must accurately process date and time data if the other information technology properly exchanges date and time data with it. Mission-critical systems are defined as those systems and interfaces which materially affect the M+C Organization's accurate and timely performance of the functions under this contract.

**[422.502(j)]**

## Article IV

## HCFA Payment to M+C Organization

A. The M+C Organization agrees to develop its annual adjusted community rate (ACR) proposal and submit to HCFA all required information on premiums, benefits, and cost sharing by May 1 of each year, as required under 42 CFR 422, subpart G. **[422.502(a)(10)]**

B. Methodology. HCFA agrees to pay the M+C Organization under this contract in accordance with the payment rules in subpart F of part 422. HCFA agrees to make monthly payments based on the greatest of the blended capitation rate under § 422.252(a), the minimum amount rate under § 422.252(b), or the minimum percentage increase rate under § 422.252(c), as adjusted by such demographic risk factors as a beneficiary's age, disability status, sex, institutional status, and such factors as HCFA determines appropriate per § 422.250(a) **[422.502(a)(9)]**

C. Certification of data that determine payment. As a condition for receiving a monthly payment under paragraph B of this article, subpart F of part 422, the M+C Organization agrees that its chief executive officer (CEO) or chief financial officer (CFO) must request payment under the contract on the forms attached as Attachment A (enrollment certification) and Attachment B (inpatient encounter data and adjusted community rate (ACR) proposal information certification) hereto which certify the accuracy, completeness, and truthfulness of the data identified on these attachments. Attachment A requires certification based on best knowledge, information, and belief, that each enrollee for whom the M+C Organization is requesting payment is validly enrolled in an M+C plan offered by the M+C Organization. The M+C Organization shall submit completed enrollment certification forms to HCFA on a monthly basis.

In addition, the following certifications shall be made on Attachment B by the CEO or CFO of an M+C Organization when the M+C Organization submits the following types of information to HCFA:

(1) Based on best knowledge, information, and belief, the inpatient encounter data the M+C Organization submits under § 422.257 are accurate, complete, and truthful. If such encounter data are generated by a related entity, contractor, or subcontractor of the M+C Organization, such entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data.

**[422.502(l)]**

(2) Based on best knowledge, information, and belief, all information and documentation comprising the ACR proposal are accurate, complete, and truthful. The M+C Organization must submit its ACR proposal(s) to HCFA by May 1 of each year. **[422.502(m)]**

## Article V

## M+C Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the M+C Organization may have with related entities, contractors, or subcontractors, the M+C Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with HCFA. **[422.502(i)(1)]**

B. The M+C Organization agrees to require all related entities, contractors, or subcontractors to agree that--

(1) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s),or subcontractor(s) involving transactions related to the this contract; and

(2) HHS's, the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 6 years from the final date of the contract period or from the date of completion of any audit, whichever is later. **[422.502(i)(2)]**

C. The M+C Organization agrees that all contracts or written arrangements into which the M+C Organization enters with providers, related entities, contractors, or subcontractors on or after January 1, 1999 shall contain each of the contract elements stated below. For those providers, related entities, contractors, or subcontractors with which the M+C Organization has a contract or written agreement prior to January 1, 1999, the M+C Organization agrees to design and implement a plan for securing on or before December 31, 1999 contracts or written arrangements with such parties which contain each of the contract elements stated below. HCFA will consider the M+C Organization's progress in implementing this requirement as a factor in its decision, required by May 1, 1999, to renew the M+C Organization's contract for 2000. The required contract elements are as follows:

(1) Enrollee protection provisions that provide--

(a) Consistent with Article III(C), arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the M+C Organization; and

(b) Consistent with Article III(C), provision for the continuation of benefits.

(2) Accountability provisions that indicate that--

(a) The M+C Organization oversees and is accountable to HCFA for any functions or responsibilities that are described in these standards; and

(b) The M+C Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this article.

(3) A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the M+C Organization will be consistent and comply with the M+C Organization's contractual obligations.

**[422.502(i)(3)]**

D. If any of the M+C Organizations's activities or responsibilities under this contract with HCFA are delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

(1) Written arrangements must specify delegated activities and reporting responsibilities.

(2) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where HCFA or the M+C Organization determine that such parties have not performed satisfactorily.

(3) Written arrangements must specify that the performance of the parties is monitored by the M+C Organization on an ongoing basis.

(4) Written arrangements must specify that either--

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the M+C Organization; or

(b) The credentialing process will be reviewed and approved by the M+C Organization and the M+C Organization must audit the credentialing process on an ongoing basis.

(5) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and HCFA instructions.
**[422.502(i)(4)]**

E. If the M+C Organization delegates selection of the providers, contractors, or subcontractors to another organization, the M+C Organization's written arrangements with that organization must state that the M+C Organization retains the right to approve, suspend, or terminate any such arrangement.
**[422.502(i)(5)]**

Article VI

Records Requirements

A. MAINTENANCE OF RECORDS

1. The M+C Organization agrees to maintain for 6 years books, records, documents, and other evidence of accounting procedures and practices that--

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the ACR) of the M+C Organization.

(ii) Enable HCFA to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the M+C Organization.

(iii) Enable HCFA to audit and inspect any books and records of the M+C Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the ACR proposal.

(v) Establish component rates of the ACR for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the M+C Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and six prior periods.

(iii) Federal income tax or informational returns for the current contract period and six prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts, and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the M+C Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.

**[422.502(d)]**

2. Access to facilities and records. The M+C Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means--

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the M+C Organization; and

(iii) The enrollment and disenrollment records for the current contract period and six prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the M+C Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The M+C Organization agrees to make available, for the purposes specified in section (A) of this article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that HCFA may require, in a manner that meets HCFA record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 6 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) HCFA determines there is a special need to retain a particular record or group of records for a longer period and notifies the M+C Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the M+C Organization, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determine that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the M+C Organization at any time. **[422.502(e)]**

B. REPORTING REQUIREMENTS

1. The M+C Organization shall have an effective procedure to develop, compile, evaluate, and report to HCFA, to its enrollees, and to the general public, at the times and in the manner that HCFA requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information as described in the remainder of this section (B). **[422.516(a)]**

2. The M+C Organization agrees to submit to HCFA certified financial information that must include the following:

(a) Such information as HCFA may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to HCFA annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in § 422.500) between the M+C Organization and a party in interest showing that the costs of the transactions listed in paragraph (1)(d) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the M+C Organization and a party in interest if either of the following conditions is met:

(aa) Thirty-five percent or more of the costs of operation of the M+C Organization go to a party in interest.

(bb) Thirty-five percent or more of the revenue of a party in interest is from the M+C Organization. **[422.516(b)]**

(v)Requirements for combined financial statements.

(aa) The combined financial statements required by paragraph (1)(c) must display in separate columns the financial information for the M+C Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the M+C Organization showing good cause, HCFA may waive the requirement that the organization's combined financial statement include the financial information required in this paragraph (1)(d) with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the M+C Organization makes with contractors, subcontractors, and related entities.

(b) Such information as HCFA may require pertaining to the disclosure of ownership and control of the M+C Organization. **[422.502(f)(1)(ii)]**

(c) Patterns of utilization of the M+C Organization's services.

3. The M+C Organization agrees to participate in surveys required by HCFA and to submit to HCFA all information that is necessary for HCFA to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the M+C plan;

(b) The M+C monthly basic beneficiary premium and M+C monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including --

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by HCFA;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by HCFA; and

(vii) Other information determined by HCFA to be necessary to assist beneficiaries in making an informed choice among M+C plans and traditional Medicare;

(e) Information about beneficiary appeals and their disposition;

(f) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(g) Any other information deemed necessary by HCFA for the administration or evaluation of the Medicare program. **[422.502(f)(2)]**

4. The M+C Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an M+C plan, all informational requirements under § 422.64 and, upon an enrollee's, request, the financial disclosure information required under § 422.516. **[422.502(f)(3)]**

5. Reporting and disclosure under ERISA.

(a) For any employees' health benefits plan that includes an M+C Organization in its offerings, the M+C Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the M+C Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The M+C Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The M+C Organization must have the capacity to communicate with HCFA electronically. **[422.502(b)]**

7. Encounter data. The M+C Organization agrees to comply with the requirements in § 422.257 for submitting encounter data to HCFA. **[422.502(a)(8)]**

## Article VII

## Renewal of the M+C Contract

A. Renewal of contract: In accordance with § 422.506, the contract is renewable annually only if-

(1) HCFA informs the M+C Organization that it authorizes a renewal; and

(2) The M+C Organization has not provided HCFA with a notice of intention not to renew. **[422.504(c)]**

B. Nonrenewal of contract:

(1) Nonrenewal by the Organization.

(a) In accordance with § 422.506, the M+C Organization may elect not to renew its contract with HCFA as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in paragraphs (b) and (c) of this paragraph.

(b) If the M+C Organization does not intend to renew its contract, it must notify--

(i) HCFA in writing, by May 1 of the year in which the contract would end;

(ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area of the M+C plans that the M+C Organization offers, including alternative M+C plans, original Medicare, and Medigap options and must receive HCFA approval.

(iii) The general public, at least 90 days before the end of the current calendar year, by publishing a HCFA-approved notice in one or more newspapers of general circulation in each community located in the M+C Organization's service area.

(c) HCFA may accept a nonrenewal notice submitted after May 1 if--

(i) The M+C Organization notifies its Medicare enrollees and the public in accordance with paragraph (1)(b)(ii) and (1)(b)(iii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(d) If the M+C Organization does not renew a contract under this paragraph (1), HCFA will not enter into a contract with the Organization for 5 years from the date of contract separation unless there are special circumstances that warrant special consideration, as determined by HCFA.
**[422.506(a)]**

(2) HCFA decision not to renew.

(a) HCFA may elect not to authorize renewal of a contract for any of the following reasons:

(i) The M+C Organization has not fully implemented or shown discernable progress in implementing quality assessment and performance improvement projects as defined in § 422.152(d).

(ii) The M+C Organization's level of enrollment, growth in enrollment, or insufficient number of contracted providers is determined by HCFA to threaten the viability of the organization under the M+C program and or be an indicator of beneficiary dissatisfaction with the M+C plan(s) offered by the organization.

(iii) For any of the reasons listed in § 422.510(a) [Article VII, section (B)(1)(a) of this contract], which would also permit HCFA to terminate the contract.

(iv) The M+C Organization has committed any of the acts in § 422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under subpart O of part 422.

(b) Notice. HCFA shall provide notice of its decision whether to authorize renewal of the contract as follows:

(i) To the M+C Organization by May 1 of the contract year.

(ii) To the M+C Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(iii) To the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community or county located in the M+C Organization's service area.

(c) Notice of appeal rights. HCFA shall give the M+C Organization written notice of its right to reconsideration of the decision not to renew in accordance with § 422.644.

**[422.506(b)]**

Article VIII

Modification or Termination of the Contract

A. Modification or Termination of Contract by Mutual Consent

1. The M+C Organization agrees to include in this contract such other terms and conditions as HCFA may find necessary and appropriate in order to implement the requirements of the M+C program.

2. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is terminated by mutual consent, except as provided in section (A)(3) of this article, the M+C Organization must provide notice to its Medicare enrollees and the general public as provided in § 422.512(b)(2) and (b)(3) [Article VIII, section B(2)(b) of this contract].

(b) If the contract is modified by mutual consent, the M+C Organization must notify its Medicare enrollees of any changes that HCFA determines are appropriate for notification within time frames specified by HCFA.

3. If this contract is terminated by mutual consent and replaced the day following such termination by a new M+C contract, the M+C Organization is not required to provide the notice specified in section B of this article.

**[422.508]**

B. Termination of the Contract by HCFA or the M+C Organization

1. Termination by HCFA.

(a) HCFA may terminate a contract for any of the following reasons:

(i) The M+C Organization has failed substantially to carry out the terms of its contract with HCFA.

(ii) The M+C Organization is carrying out its contract with HCFA in a manner that is inconsistent with the effective and efficient implementation of this part.

(iii) HCFA determines that the M+C Organization no longer meets the requirements of this part for being a contracting organization.

(iv) The M+C Organization commits or participates in fraudulent or abusive activities affecting the Medicare program, including submission of fraudulent data.

(v) The M+C Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) The M+C Organization substantially fails to comply with the requirements in subpart M of this part relating to grievances and appeals.

(vii) The M+C Organization fails to provide HCFA with valid encounter data as required under § 422.257.

(viii) The M+C Organization fails to implement an acceptable quality assessment and performance improvement program as required under subpart D of § 422.

(ix) The M+C Organization substantially fails to comply with the prompt payment requirements in § 422.520.

(x) The M+C Organization substantially fails to comply with the service access requirements in § 422.112 or § 422.114.

(xi) The M+C Organization fails to comply with the requirements of § 422.208 regarding physician incentive plans.

(b) Notice. If HCFA decides to terminate a contract for reasons other than the grounds specified in section (B)(1)(a) above, it will give notice of the termination as follows:

(i) HCFA will notify the M+C Organization in writing 90 days before the intended date of the termination.

(ii) The M+C Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The M+C Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the M+C Organization's service area.

(c) Immediate termination of contract by HCFA.

(i) For terminations based on violations prescribed in paragraph (B)(1)(a)(v) of this article, HCFA will notify the M+C Organization in writing that its contract has been terminated effective the date of the termination decision by HCFA. If termination is effective in the middle of a month, HCFA has the right to recover the prorated share of the capitation payments made to the M+C Organization covering the period of the month following the contract termination.

(ii) HCFA will notify the M+C Organization's Medicare enrollees in writing of HCFA's decision to terminate the M+C Organization's contract. This notice will occur no later than 30 days after HCFA notifies the plan of its decision to terminate this contract. HCFA will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative M+C Organizations in a similar geographic area and original Medicare.

(iii) HCFA will notify the general public of the termination no later than 30 days after notifying the M+C Organization of HCFA's decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the M+C Organization's service area.

(d) Corrective action plan

(i) General. Before terminating a contract for reasons other than the grounds specified in section (B)(1)(a)(v) of this article, HCFA will provide the M+C Organization with reasonable opportunity, not to exceed time frames specified at subpart N of § 422, to develop and receive HCFA approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exception. If a contract is terminated under section (B)(1)(a)(v) of this article, the M+C Organization will not have the opportunity to submit a corrective action plan.

(e) Appeal rights. If HCFA decides to terminate this contract, it will send written notice to the M+C Organization informing it of its termination appeal rights in accordance with subpart N of § 422.

**[422.510]**

2. Termination by the M+C Organization

(a) Cause for termination. The M+C Organization may terminate this contract if HCFA fails to substantially carry out the terms of the contract.

(b) Notice. The M+C Organization must give advance notice as follows:

(i) To HCFA, at least 90 days before the intended date of termination. This notice must specify the reasons why the M+C Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative M+C plans, Medigap options, and original Medicare and must receive HCFA approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a HCFA-approved notice in one or more newspapers of general circulation in each community or county located in the M+C Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by HCFA and will be at least 90 days after the date HCFA receives the M+C Organization's notice of intent to terminate.

(d) HCFA's liability. HCFA's liability for payment to the M+C Organization ends as of the first day of the month after the last month for which the contract is in effect.

(e) Effect of termination by the organization. HCFA will not enter into an agreement with the M+C Organization for a period of five years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by HCFA. **[422.512]**

## Article IX

## Requirements of Other Laws and Regulations

A. The M+C Organization agrees to comply with--

(1) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84;

(2) The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;

(3) The Americans With Disabilities Act; and

(4) Other laws applicable to recipients of Federal funds; and

(5) All other applicable laws, regulations, and rules.

**[422.502(h)(1)]**

B. The M+C Organization is receiving Federal payments under this contract, and related entities, contractors, and subcontractors paid by the M+C Organization to fulfill its obligations under this contract are subject to certain laws that are applicable to individuals and entities receiving Federal funds.

The M+C Organization agrees to inform all related entities, contractors and subcontractors that payments that they receive are, in whole or in part, from Federal funds.
**[422.502(h)(2)]**

C. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an M+C Organization, the provisions of the statute or regulation shall have full force and effect. **[422.502(j)]**

## Article X

## Severability

The M+C Organization agrees that, upon HCFA's request, this contract will be amended to exclude any M+C plan or State-licensed entity specified by HCFA, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.
**[422.502(k)]**

In witness whereof, the parties hereby execute this contract.

FOR THE M+C ORGANIZATION

_____ _____

Printed Name Title

_____ _____

Signature Date

_____ _____

Organization

_____

Address

FOR THE HEALTH CARE FINANCING ADMINISTRATION

_____

Gary A. Bailey
Director, Health Plan Purchasing
and Administration Group
Center for Health Plans and Providers

**ATTACHMENT A**

**CERTIFICATION OF ENROLLMENT INFORMATION RELATING TO HCFA PAYMENT TO A MEDICARE+CHOICE ORGANIZATION**

Pursuant to the contract(s) between the Health Care Financing Administration (HCFA) and (INSERT NAME OF M+C ORGANIZATION), hereafter referred to as the "M+C Organization," governing the operation of the following Medicare +Choice plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the M+C Organization hereby requests payment under the contract, and in doing so, makes the following certifications concerning HCFA payments to the M+C Organization. The M+C Organization acknowledges that the information described below directly affects the calculation of HCFA payments to the M+C Organization and that misrepresentations to HCFA about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

1. The M+C Organization has reported to HCFA for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and changes in enrollees' institutional status with respect to the above-stated M+C plans. Based on best knowledge, information, and belief, all information submitted to HCFA in this report is accurate, complete, and truthful.

2. The M+C Organization has reviewed the HCFA monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated M+C plans and has reported to HCFA any discrepancies between the report and the M+C Organization's records. For those portions of the monthly membership report and the reply listing to which the M+C Organization raises no objection, the M+C Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief, to their accuracy, completeness, and truthfulness.

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(INDICATE TITLE [CEO or CFO])
on behalf of
(INDICATE M+C ORGANIZATION)

**ATTACHMENT B**

**CERTIFICATION OF ENCOUNTER AND ADJUSTED COMMUNITY RATE INFORMATION RELATING TO HCFA PAYMENT TO A MEDICARE+CHOICE ORGANIZATION**

Pursuant to the contract(s) between the Health Care Financing Administration (HCFA) and (INSERT NAME OF M+C ORGANIZATION), hereafter referred to as the "M+C Organization," governing the operation of the following Medicare +Choice plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the M+C Organization hereby requests payment under the contract, and in doing so, makes the following certifications concerning HCFA payments to the M+C Organization. The M+C Organization acknowledges that the information described below directly affects the calculation of HCFA payments to the M+C Organization or additional benefit obligations of the M+C Organization and that misrepresentations to HCFA about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

1. The M+C Organization has reported to HCFA for the period of (INDICATE DATES) all inpatient encounter data with respect to the above-stated M+C plans. Based on best knowledge, information, and belief, all information submitted to HCFA in this report is accurate, complete, and truthful.

2. The M+C Organization has submitted to HCFA an adjusted community rate (ACR) proposal for the period (INDICATE DATES). Based on best knowledge, information, and belief, all of the information submitted to HCFA in this ACR proposal is accurate, complete, and truthful.

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(INDICATE TITLE [CEO or CFO])
on behalf of
(INDICATE M+C ORGANIZATION)